UNITED NATIONS

E

Economic and Social Council

Distr.
LIMITED

E/ICEF/1991/P/L.23
20 March 1991
ENGLISH
ORIGINAL: ENGLISH/FRENCH

UNITED NATIONS CHILDREN'S FUND
Programme Committee
1991 session

FOR ACTION

RECOMMENDATION FOR FUNDING FROM GENERAL RESOURCES AND SUPPLEMENTARY FUNDS FOR PROGRAMMES IN THE MIDDLE EAST AND NORTH AFRICA REGION WITH ANNUAL PLANNING LEVELS NOT EXCEEDING $750,000

SUMMARY

The present document contains recommendations for funding from general resources and supplementary funds for programmes with annual planning levels not exceeding $750,000. The Executive Director recommends that the Executive Board approve the following amounts from general resources, subject to the availability of funds, and the following amounts in supplementary funds, subject to the availability of specific-purpose contributions, for the country programmes listed below:

Country/programme	Amount (United States dollars)		Duration
	General resources	Supplementary funds	
Oman	3 750 000	-	1991-1995
Tunisia	3 750 000	2 500 000	1992-1996
Palestinian children and women in the Syrian Arab Republic	800 000	800 000	1991-1994

Summaries of individual recommendations follow.

READEX FICHE

I. OMAN

U5MR: 40
IMR: 35
GNP per capita: $5,810

Child population (0-15 years): 800,000
Literacy (male/female): 60/40 per cent
Access to health services: 91 per cent

One-year-olds fully immunized against:

tuberculosis:	92 per cent
diphtheria/pertussis/tetanus:	96 per cent
measles:	90 per cent
poliomyelitis:	96 per cent

Pregnant women immunized against:

tetanus:	70 per cent

The situation of children and women

1. Oman stands out as a remarkable example of the dramatic successes that can be achieved in a limited period of time through political commitment and the mobilization of human and financial resources. From a virtual zero base, national development advanced, with particular attention to social development. Over the past decade, infant and under-five child mortality have been reduced to less than one third of 1980 levels - from 100 to 35 per 1,000 live births and from 146 to 40 per 1,000 live births, respectively. National attention is now focused on problems related to targeting the main direct causes of infant and young child mortality and morbidity, improving child and maternal nutrition and reducing gender and regional disparities in the delivery of health and education services.

2. The Sultanate of Oman has an estimated population of 1.6 million, of whom approximately half are under 15 years of age. With 35 per cent of women in the reproductive age-group, the fertility rate is about 7 per 1,000, the population growth rate is estimated at 3.3 per cent and the crude birth rate is 44 per 1,000. The majority of the population live in rural areas, mostly in small villages scattered amidst often harsh mountainous or desert terrain, with few roads and erratic water sources.

3. The continued vulnerability to changes in oil prices is a constant uncertainty since the economy is dependent on oil reserves. Long-term diversification is constrained by a small domestic market, relatively few exploitable natural resources, water constraints on agricultural expansion and shortages of technical and skilled domestic staff. There is a heavy reliance on foreign workers in industry, education and health.

4. The majority of infant deaths today are a result of problems related to knowledge and practices originating in the antenatal and post-natal periods. Neonatal mortality ranges from an average of 21 to a high of 38 per 1,000 live

births. Respiratory infections, septicaemia and congenital anomalies are other major causes of infant and child mortality and morbidity. Acute respiratory infections (ARI) account for 10 per cent of all hospital admissions of children and infant deaths.

5. Although diarrhoea-related mortality is no longer a problem, there is a lack of knowledge at the community level about how to mix oral rehydration salts (ORS) correctly, and the incidence of diarrhoea remains a concern. Malaria is increasingly becoming a public health problem, with some 20,000 cases reported in 1988, compared with 11,400 in 1987 and 11,100 in 1986. Some 20 per cent of the population suffer from mild to severe trachoma, with 3 per cent blind in both eyes and another 3 per cent blind in one eye owing to trachoma-related causes. Much of this is caused by poor sanitation and hygiene practices.

6. A 1988 nutrition study undertaken jointly by the Ministry of Health and UNICEF Oman showed that the incidence of low birth weight ranges from 6.5 to 14.3 per cent. It indicated that 30 per cent of infants are given supplementary foods before they reach the age of four months and that weaning practices are poor. It also pointed to gender disparities, with a shorter duration of breast-feeding and more frequent diarrhoeal episodes for girls. Some 63 per cent of adolescent girls between the ages of 11 and 19 years old were undernourished. Furthermore, hospital records showed that the incidence of low birth weight ranged from 6.5 to 14.3 per cent.

7. Childhood disability in Oman is a serious problem, although the causes and magnitude of the problem are not well documented. There is a shortage of trained personnel to assess the problem and initiate a national programme that focuses on prevention and care. Increasingly, children are becoming victims of a wide range of accidents. Accident victims account for around 11 per cent of hospital admissions and 8 per cent of out-patient cases.

8. Some 90 per cent of children attend primary schools, with negligible drop-out rates, while secondary school attendance is around 80 per cent of the eligible child population. The challenge is to motivate children starting from primary school onwards and to prepare them adequately for national job opportunities and diversification plans. Early childhood development activities, a recent development, reach only around 5 per cent of eligible children, owing to the paucity of facilities and trained personnel and the low awareness standards of mothers.

9. Literacy rates have improved substantially over the past decade, but remain relatively low, with 50 per cent of the population over 15 years of age (60 per cent male and 40 per cent female) literate in 1989.

Programme cooperation, 1985-1990

10. The programme focused on lowering infant and child mortality rates through the nation-wide application of simple and effective techniques that addressed the major causes of death. These were coupled with educational

programmes for families, particularly women, using all available communications channels, including the mass media, health professionals and community workers. The programme included a number of interrelated and mutually reinforcing components chosen on the basis of their relevance to priority child health problems and their replicability nation-wide.

11. The expanded programme on immunization (EPI) was intensified nationally in 1985 so that by 1989 the incidence of the six immunizable diseases had been reduced to negligible levels. Measles cases were reduced dramatically from 38,000 in 1981, when the programme began, to about 4,000 in 1985, and pertussis from 2,000 cases in 1981 to some 800 in 1985. No cases of neonatal tetanus have been reported in Oman since 1989 and coverage for the six antigens reached 95 per cent in 1990. When UNICEF phased out its vaccine supply, assistance continued for training and refresher courses for 40 per cent of health workers involved in the control of diarrhoeal diseases (CDD), ARI and maternal and child health (MCH) services.

12. A CDD programme began in the mid-1980s, with UNICEF financial and technical support for training and the development of supporting materials. Diarrhoea-related mortality among children under the age of four years declined from 20 per cent in 1984 to 6.7 per cent in 1988. As in the case of vaccines, UNICEF financial support for the supply of ORS was phased out by 1987.

13. Launched in 1988, the national antenatal programme provides pregnant women with regular check-ups. Antenatal cards are distributed to expectant mothers and service utilization rates and attendance have improved. With over 80 per cent of deliveries taking place in hospitals, there is a foundation for a good antenatal and post-natal programme to reduce pregnancy risks and complications, as well as low birth weight and still births.

14. A national ARI programme, with standardized case management, was launched in mid-1987 to improve public awareness of preventive measures, early diagnosis and care. Training and information materials for health personnel and the public were developed.

15. The national child health programme that was launched in 1989 promoted the monitoring of young child growth and development and provided children with comprehensive, individual health cards.

16. UNICEF provided financial and technical support for training and the development of reference and training materials for the EPI, CDD, ARI, antenatal care and child health programmes.

17. A booklet on recognizing and treating protein-energy malnutrition was designed and produced for Oman. It was introduced to health workers through a UNICEF-supported national training workshop. Two national nutritional workshops were sponsored jointly by UNICEF and the agricultural sector, with the participation of other ministries.

18. Following a national workshop on water and environmental sanitation, joint interministerial field visits were undertaken in 1990 with the participation of UNICEF and the World Health Organization (WHO) to identify villages for model projects. The workshop increased local-level interest in improving environmental conditions, as well as in the effective garbage disposal programme of the Ministry of Regional Municipalities.

19. The national community development programme has been implemented in around 350 villages and 375 smaller population centres. In addition to a number of community-based actions, the programme emphasizes the development of rural women as pivotal elements in family and community development. In coordination with the Ministry of Social Affairs, UNICEF has supported annual training and refresher courses for all community workers in EPI, CDD, infant nutrition and other preventive health care areas. These complement activities undertaken by the Ministry of Health.

20. The National Woman and Child Care Plan, established in 1988 with UNICEF advocacy, provides the important multisectoral base for programmes for children. Its special features include monitoring programme interventions that require intersectoral support, emphasizing manpower development and information dissemination. UNICEF provided technical and financial support for the development of resource and training materials, for mass media programmes and for training of community workers.

21. In 1989, UNICEF began its cooperation and financial support to the Ministry of Education for adapting the literacy curriculum to national reality, pre-school teacher training and curriculum development. The need for materials to sustain literacy skills was strengthened with a workshop to promote local writing of post-literacy and reading materials for children.

22. The use of communications and mobilization channels, especially television, has been effective in spreading important messages on a variety of social issues. UNICEF was directly involved in the production of a variety of television spots, as well as 10 half-hour television programmes on child survival and development (CSD).

23. UNICEF provided financial and technical support for rapid assessments and special technical studies involving the London School of Hygiene and Tropical Medicine, the Centers for Disease Control in the United States and the American University of Beirut. The studies were carried out so as to understand better the nutritional, environmental and health situation of children and to establish the methodology for the collection of health statistics and the dissemination of health information.

24. UNICEF has collaborated closely with other United Nations organizations. UNICEF and WHO jointly supported EPI, oral rehydration therapy (ORT) and hygiene and sanitation programmes and conducted joint evaluations with the Ministry of Health. The national community development programme is assisted by both UNICEF and the United Nations Development Programme (UNDP), particularly during the programme preparation and monitoring stages.

Lessons learned

25. To sustain recent gains and achieve further progress, high standards of successful programmes need to be maintained through continuous training and refresher courses, with an emphasis on Arabic-speaking staff. Future interventions will have to make full use of the intersectoral mechanisms that have now gained credibility with all government partners to focus on community-based actions.

Recommended programme cooperation, 1991-1995

Estimated annual expenditure

(In thousands of United States dollars)

	1991	1992	1993	1994	1995	Total
Health and nutrition	157	233	182	232	251	1 055
Education	93	30	43	40	24	230
Water supply and sanitation	85	80	80	80	80	405
Community development	90	62	100	98	100	450
Social mobilization and advocacy	130	200	205	150	150	835
Programme support	195	145	140	150	145	775
Total	750	750	750	750	750	3 750

26. The objectives of the 1991-1995 programme of cooperation are based on the problems outlined earlier and will contribute towards achieving and sustaining the goals for the 1990s. The programme aims to contribute to keeping women and children on the national agenda. It aims to improve further the health and quality of life and to eliminate gender and regional disparities in health, nutrition and education. By 1995, it aims to reduce infant and under-five mortality by 2.5 per cent each year from the present rates of about 35 and 40 per 1,000 live births, respectively.

Health and nutrition

27. Maternal and child health. This project aims to reduce the proportion of babies with low birth weight from 15 to 10 per cent of the 1990 rates, stillbirths by 70 per cent and maternal mortality by 50 per cent. UNICEF support to MCH will focus on "at risk" pregnant women and on improving appropriate reporting and recording systems through the development of quality reference and training materials and the training and retraining of staff.

28. Expanded programme on immunization. The project aims to eliminate poliomyelitis and to sustain the high coverage and negligible incidence levels of diphtheria, pertussis, tetanus and measles. The project will also focus on reducing the work of the defaulter retrieval system through improved awareness

of mothers and increased community interest to achieve high coverage, as well as on reducing gender and regional disparities associated with the incidence of diseases. UNICEF assistance will focus on maintaining an efficient cold-chain system, as well as on training and refresher courses for health staff.

29. Control of diarrhoeal diseases. The project aims to reduce diarrhoea-related mortality by 50 per cent and incidence by 30 per cent of 1990 levels. The project will focus on teaching mothers to mix ORS correctly and to administer ORT at home. It will emphasize breast-feeding and proper feeding practices, as well as reducing the incidence of diarrhoea through improved sanitation and hygiene conditions.

30. Control of acute respiratory infections. The project aims to reduce mortality and morbidity caused by ARI by 20 per cent of the 1990 levels based on a baseline survey. Coordinated by the National Women and Child Care Plan, the project will involve the Ministry of Health, as well as the non-health sector. It will maintain an efficient health delivery system and well-informed staff who will manage ARI and educate parents on prevention, early detection and treatment. Information on the harmful effects of smoking will also be disseminated. With technical and financial support from UNICEF, reference and training materials will be developed and workshops will be organized on a regular basis at the national, regional and local levels. Staff will be trained and retrained on ARI and other health topics. Data will be collected systematically to monitor the programme.

31. Trachoma and malaria projects. These projects aim to reduce the incidence of trachoma by 80 per cent and malaria-related mortality by 50 per cent of the 1990 levels. The disability and accidents project aims to reduce preventable handicaps by 50 per cent of the 1991 level and to reduce child accidents by 50 per cent of 1990 levels. The school health project aims to achieve good health for all schoolchildren, with an emphasis on teenage girls. Both projects will be intensified nationally through the training of health and non-health workers. Workshops will be held at national and regional levels and supported by nationally relevant resource and training materials. UNICEF will provide technical and financial support for the production of materials and for conducting training workshops. With regard to disabilities, UNICEF will provide technical and financial support to an interministerial approach to understanding the situation and plan interventions.

32. Nutrition. The project aims to have 80 per cent of mothers utilize proper breast-feeding and weaning practices. Child malnutrition will be reduced by 50 per cent of 1990 levels and iron deficiency anaemia in women by one third of 1990 levels. Surveys and special studies will be conducted to assess the magnitude of malnutrition and micronutrient deficiencies. Nutrition interventions will focus on infants, pre-school children, adolescent girls and pregnant women. The participation of agricultural institutions and the commercial sector will be necessary to support food production, consumption and import policies that will in turn support national interests

and priorities. UNICEF will provide consultancy inputs for special studies, the development of materials and training.

Water supply and environmental sanitation

33. The programme aims to provide access to safe sanitation facilities to 85 per cent of urban and 30 per cent of rural populations. The findings of the national study on water supply and sanitation will be used to plan and implement national programmes, beginning with selected villages. UNICEF will provide expertise in social mobilization and community development to motivate people and provide knowledge about the importance of personal hygiene, clean water sources and distribution systems and healthy environmental conditions. UNICEF assistance will focus on health education aspects and provide limited supplies.

Community development

34. The community development programme of the Ministry of Social Affairs will expand to 75 per cent of the communities in Oman, with the dissemination of knowledge and skills benefiting girls and women on a national scale. The programme will continue to receive UNICEF assistance to assess and promote women's education, to open new economic ventures for them in both rural and urban areas and to train community development workers. UNICEF will provide limited supplies and equipment to improve programme coverage.

35. By 1995, the programme plans to increase the pre-school coverage from the present 5 per cent to 20 per cent of eligible children through training and refresher courses for pre-school teachers. UNICEF will support a joint programme with the Ministries of Social Affairs and Education to increase the quality of pre-school education and early childhood stimulation through community facilities, nurseries, day-care centres, play groups and kindergartens, as well as through the education of mothers.

Education

36. By 1995, the Oman educational programme will aim to achieve nearly 100 per cent primary school attendance and over 80 per cent secondary school attendance of eligible schoolchildren. Gradual inputs will be made to improve the quality and relevance of curricula to match national reality and priorities, which should begin with primary school children. Similarly, the coverage and quality of adult literacy programmes will be extended on a national scale. UNICEF will provide consultancy inputs for these programmes, as well as for the development of post-literacy and extra-curricular reading materials.

Social mobilization and advocacy

37. The programme will focus on sustaining and improving further the situation of women and children by creating awareness of the goals outlined above, advocating strategies and empowering people with the information and knowledge they need to practice good health and other relevant habits.

38. By 1995, the mass media will be developed as a major means of supporting national programmes and community-level communications activities. Information, training and resource materials will be developed and a technical unit will be established at the central level to continue the development, production and monitoring of material. All regions will have regular, ongoing training activities through multisectoral, regional task force groups.

39. UNICEF will provide financial and technical support to the National Women and Child Care Plan to develop nationally relevant and consistent resource, training and information materials for use by non-health workers on immunization, CDD, ARI, trachoma, MCH, nutrition, birth spacing, malaria, hygiene, water and sanitation, anti-smoking, early childhood stimulation, disability, childhood accidents and other relevant topics. UNICEF will also support the organization of training workshops at national, regional and local levels. An Omani adaptation of Facts for Life will be developed.

40. Advocacy and external relations will be strengthened, using formal and informal opportunities and special events, to share international experiences and promote national programmes. Local fund-raising strategies will be developed, and possibilities will be pursued for mobilizing additional resources for national programmes for women and children. National success stories will be highlighted in order to promote wider coverage, replication, resource generation and multisectoral participation. The Government has recommended that the Convention on the Rights of the Child be ratified, and the first steps have been taken.

Monitoring and evaluation

41. Monitoring and evaluation will be extended to all social programmes and, in particular, to the achievement of the goals for the 1990s, using methods of rapid assessment techniques, where applicable, to obtain quick results for immediate application. Such activities are built into all programmes. All information and statistics will be disaggregated by gender to ensure that any inequitable impact of programmes in girls and women can be corrected. The same process will be applied for priority groups and geographical locations. In-depth surveys will continue to be undertaken on a national scale. A large-scale survey similar to the 1989 survey of family health is planned for 1992-1993.

Cooperation with United Nations organizations

42. Cooperation with UNDP, WHO and other organizations of the United Nations system will continue. Possible new areas of cooperation could include water and sanitation and the development of improved statistics on the situation of women and children. Special focus will be placed on developing inter-agency monitoring of 1990 goals against a baseline to be established by 1991.

II. TUNISIA

U5MR: 66
IMR: 51
GNP per capita: $1,180

Child population (0-15 years): 3.2 million
Literacy (male/female): 68/51 per cent
Access to health services: 90 per cent

One-year-olds fully immunized against:

tuberculosis:	85 per cent
diphtheria/pertussis/tetanus:	93 per cent
measles:	83 per cent
poliomyelitis:	91 per cent

Pregnant women immunized against:

tetanus:	34 per cent

The situation of children and women in Tunisia

43. The 1980s in Tunisia were characterized by instability relating to the fall in the prices of oil and natural gas and to the world recession, aggravated by drought. This had a negative impact on socio-economic development in general, and on that of children and women in particular.

44. In 1990, the situation in Iraq and Kuwait aggravated the economic situation: the external trade deficit was an estimated $150 million; the unemployment rate increased to 16 per cent; and the inflation rate was 8.5 per cent. Increases in the prices of consumer goods have further eroded the purchasing power of low-income families.

45. The population of Tunisia, estimated at 7.8 million inhabitants in 1990, is increasing at an annual rate of 2.5 per cent. Children under five years of age and women of child-bearing age number 1.3 million and 1.7 million, respectively. Some 59 per cent of the population live in urban areas.

46. Access to health services varies from one governorate to another, and is a further reflection of the disparity between coastal and interior regions. Despite the existence of an infrastructure of 4,000 fixed and mobile centres, the rate of utilization remains fairly low owing to a lack of information and awareness by the population of the need for consultations and monitoring in case of illness or pregnancy.

47. Infant and under-five mortality are declining. According to data provided by the Statistical Institute, the infant mortality rate (IMR) fell from 153 to 51 per 1,000 live births between 1966 and 1988. The under-five mortality rate (U5MR) fell from 184 to 66 per 1,000 live births over the same period. Nevertheless, this decrease varies from region to region, reflecting the degree of development and access to health service.

48. The incidence of the disease targeted under the national immunization programme has declined significantly since 1987. In 1989, epidemiological schedules indicated an incidence of 0 per cent for poliomyelitis and diptheria, 0.02 per cent for neonatal tetanus and 14.6 per cent for measles.

49. Neonatal mortality accounts for 50 per cent of infant mortality. Neonatal tetanus, prematurity and low birth weight are among the major causes of death. Diarrhoeal diseases account for about 40 per cent of mortality among children under the age of one year. In rural regions, the proportion reaches 73 per cent.

50. ARI is the second-ranking cause of mortality among children under five years of age. In 1985, at the Mellassine peri-urban health clinic, 35 per cent of the consultations involving children under the age of one year and 66 per cent of the consultations involving children under five years of age related to ARI. Furthermore, 15 per cent of the deaths of children under five years of age recorded in hospitals in Tunis were caused by ARI.

51. Maternal mortality, estimated at 60 per 100,000 live births, is higher in rural regions, where more than 50 per cent of deliveries are performed at home by untrained birth attendants.

52. School enrolment rates are relatively high in Tunisia, with 100 per cent for boys and 89 per cent for girls. However, the drop-out rate is significant, particularly among girls in rural areas, at 25 per cent after the sixth year of primary school. Dropping out is linked to economic and socio-cultural or geographical factors such as inaccessibility and isolation.

53. Access to information is a major benefit in mobilization and education. Television and radio, which reach some 90 per cent of the Tunisian population, contribute, inter alia, to changes in behaviour in the fields of health and education.

Programme cooperation, 1987-1990

54. The major objective of the 1987-1990 programme of cooperation was to reduce infant mortality. Universal child immunization, improved MCH services and the use of ORT helped to save the lives of thousands of children through the mobilization of various sectors and the use of social communication as a strategy in improving awareness among the population of matters relating to child survival, protection and development.

National immunization programme

55. Tunisia made significant progress in immunization by providing coverage for more than 1 million children and 500,000 women as a result of the commitment of the authorities and the participation of mass organizations and non-governmental organizations (NGOs). A 1988 coverage survey indicated a rate of 96 per cent for anti-tuberculosis vaccine (BCG), 91 per cent for three

doses each of combined diphtheria/pertussis/tetanus (DPT3) and poliomyelitis (OPV3) vaccines, 83 per cent for measles and 43 per cent for anti-tetanus immunization. Through social mobilization and health education, 96 per cent of mothers recognized the importance of immunization to child health. UNICEF provided technical assistance in the fields of disease surveillance, personnel training, supply of vaccine and equipment for the cold chain, transport for supervision and the production of communication materials.

National diarrhoea control programme

56. Initiated in 1980, the diarrhoea control programme had a marked impact in terms of reducing infant mortality. A 1988 survey indicated that mortality had declined from 6.5 to 4.8 per 1,000 live births. Furthermore, the number of cases fell from 4.5 to 3.5 per annum per child under five years old. The improvement was largely due to the correct preparation of rehydration solutions by 87 per cent of mothers. The programme was complemented by a social communication strategy concerning dehydration and the use of ORT, including the production of 30 television and radio spots.

57. The development of human resources at various levels began with the training of 23 instructors who, in turn, trained one third of the medical and paramedical personnel in the public sector. With the cooperation of professional organizations, 100 private paediatricians and pharmacists were also trained. To provide for decentralization in training, five training centres were established at Tunis, Sfax, Sousse and Gafsa. Cooperation with UNICEF made it possible to improve the information and supervision system and to produce communication materials.

Maternal and child health

58. The MCH programme covered prenatal and post-natal care, the promotion of breast-feeding, nutrition education and growth monitoring. In that connection, three surveys were conducted in 1989: the first related to prenatal consultation in health centres, the second to the view of prenatal monitoring held by women of child-bearing age, and the third to an evaluation of coverage and the impact on health professionals. The survey showed that only 45 per cent of women made use of MCH services and that only 65 per cent of health professionals had been trained in MCH programme and activities management and evaluation. On the basis of those findings, a national strategy and plan of action to develop the capacities of personnel in the public and private sectors were devised and implemented. The plan covered almost all instructors at national and regional levels with regard to the evaluation of high-risk pregnany treatment systems and the motivation of women in terms of using such services.

59. UNICEF provided technical assistance in the areas of evaluation, training, improvement of the data collection system, computerization and analysis of data, supply of baby scales and the production of communication materials.

Social communication

60. Social communication, with the aim of improving the awareness of target populations, was integrated into all basic health activities and primary education programmes. At the same time the public benefited, through the media, national organizations and NGOs, from communication programmes relating to the survival and development of mothers and children. UNICEF support involved the training of health personnel, the production of communication materials and the evaluation of programme activities.

Monitoring and evaluation

61. The lack of data on the incidence of diseases affecting children under five years of age, as well as on the geographical incidence and distribution by age and sex of such diseases, led to the development of evaluation and monitoring activities. Coverage and knowledge, attitude and practice surveys were conducted for all national programmes. The results obtained have improved the planning of field activities. The contribution of UNICEF related to training, in order to develop national capacity in the field of monitoring and evaluation, in particular through computerization of the system.

Lessons learned

62. It appears that the social mobilization strategy had a positive impact on programme acceleration and the attainment of its objectives; similarly, planning by objectives was proved to be an effective means of implementing activities. Combined with the impact of the media on the target populations, these procedures have demonstrated the potential for attaining ambitious objectives with modest financial resources. These procedures will continue to support programme implementation for the period 1992-1996.

Recommended programme cooperation, 1992-1996

Estimated annual expenditure

(In thousands of United States dollars)

	1992	1993	1994	1995	1996	Total
General resources						
Health	440	440	440	440	440	2 200
Education	210	210	210	210	210	1 050
Advocacy/planning	100	100	100	100	100	500
Total	750	750	750	750	750	3 750
Supplementary funding						
Health	250	250	250	250	250	1 250
Education	250	250	250	250	250	1 250
Total	500	500	500	500	500	2 500
Grand total	1 250	1 250	1 250	1 250	1 250	6 250

63. The programme of cooperation recommended for the period 1992-1996 comprises programmes in three sectors: health, including MCH, immunization, CDD and control of ARI; education, including pre-school education, primary education and education for health in schools; and advocacy, comprising two projects on social planning and advocacy.

64. The proposed programme of cooperation is aimed at improving MCH, particularly in the most underprivileged regions; at guaranteeing children the basic level of education necessary to their development; and at improving the awareness and behaviour of target populations so as to consolidate the protection, survival and development of children and mothers.

Health programme

65. This programme is designed to reduce IMR from 45 to 25 per 1,000 live births; reduce U5MR from 60 to 30 per 1,000 live births; and reduce maternal mortality from 60 to 30 per 100,000 live births. The health programme proposes to develop human and institutional resources in the field of primary health care (PHC), particularly in the most underprivileged regions, and to improve awareness of health matters among the general public, particularly among schoolchildren and mothers.

66. Maternal and child health care. By 1996, the project intends to provide at least 80 per cent of mothers and children with MCH services, including in

rural areas. The programme will consolidate earlier progress and extend and develop MCH services at all levels through the health district approach, which involves the gradual integration of prenatal care, training of birth attendants, immunization of women and children, CDD and ARI control and monitoring of complicated pregnancies at risk for premature birth and low birth weight. UNICEF will support a feasibility study on the training of birth attendants in rural areas, which will be used as basis to extend the approach to all rural areas.

67. The project will include the gradual development of national capacity for the planning, management, supervision and evaluation of integrated MCH services at the regional and local levels. This will be based on practical courses. Social mobilization and community participation will be further developed through the reinvigoration of local health councils and NGOs. The organization of an information and monitoring system, together with operational research, will constitute the principal source of information guiding appropriate field activities.

68. National immunization project. By 1996, the project intends to maintain immunization coverage of children and mothers, to eradicate poliomyelitis and neonatal tetanus and to reduce the incidence of measles from 14.6 per cent to 5 per cent. This approach is in line with the general policy of basic health care, which also involves strengthening immunization teams in peripheral areas. These teams will be needed to contribute to the success of regional campaign days, which will be organized in governorates with low rates of coverage. UNICEF will provide for maintenance of the cold chain and the development of monitoring and evaluation, management and supervision systems. UNICEF will support training at the regional and peripheral levels, as well as the integration of immunization activities into overall basic health care activities.

69. National diarrhoea control project. By 1996, the project aims to reduce diarrhoea-related mortality from 4.8 to 2 per 1,000 children under the age of five years. The strategy devised under this project will further reduce incidence of diarrhoea and diarrhoea-related mortality. This implies integration of the project into other PHC activities and the development of a training plan for personnel in the public and private sectors, based on treatment of the diarrhoeal child, disease surveillance, programme management, data collection and evaluation and monitoring. This training strategy must be conducted at the central level for instructors, and at the regional and peripheral levels for medical and paramedical personnel.

70. Mobilization, which will promote ORT, breast-feeding and better weaning practices, will be conducted jointly by health personnel, through direct contacts, and by the media and volunteers. UNICEF will provide technical assistance for implementation of the plan of action, evaluation management, training and social mobilization through the production of communication materials.

71. Control of acute repiratory infections. By 1996, the project aims to reduce ARI-related mortality, which needs to be determined, by 25 per cent among children under five years of age. The project will be based on information gathered in the course of research which will be conducted, taking into account specific trials carried out in the Governorate of Tunis and the north-east. The results of the research will also enable the development of a national policy, which will focus on the integration of ARI into PHC activities and on the training of personnel in treatment (including for cases of pneumonia), management, evaluation and monitoring and data collection. The second aspect of the project will include educating parents in the prevention and identification of ARI symptoms, treatment and counselling at the nearest health centre in the event of difficulties . This educational activity will be performed by health personnel and will be supported by a communication strategy involving other personnel. Research will be conducted as to which antibiotics should be used and who should prescribe them. UNICEF will provide assistance in research, training, social communication, evaluation, disease surveillance and data collection.

Education programme

72. Pre-school education. By 1996, the project, which aims to extend pre-school coverage from 5 to 25 per cent, will help to promote early childhood development and to educate mothers in CSD principles. Using the pre-school children to develop their mothers' awareness of the concepts of "facts for life" will result in lower costs and reach the maximum number of children. Particular attention will be paid to the training of staff entrusted with implementing this new policy.

73. Primary education. By 1996, the project aims to lower the school drop-out rate, particularly among rural girls, from 25 to 10 per cent. The project will be based on a mobilization strategy to be formulated on the basis of a school-drop out survey to be conducted beginning in 1991. The strategy will be developed by the Tunisian Women's Union and will be conducted at various levels, reaching teachers, children and their families. The project will also aim to improve the quality of teaching in an attempt to foster a critical faculty in children, in line with the "basic school" developed by Tunisia in its restructuring of the education system.

74. Health education in schools. By 1996, the project aims to improve the knowledge and habits of children from early childhood onwards, in terms of basic health and the transmission of knowledge acquired by the child within the family. The child will thus serve as a link between school and family. The project will consolidate earlier progress and will focus on the training of regional inspectors and some 15,000 teachers. Over the next five years the programme will cover the entire primary-school cycle.

75. UNICEF will provide technical support for research on various projects and for training to promote national capacities, technical assistance for social communication and the production of educational materials and for evaluation, management and supervision.

Advocacy programme

76. The programme, based on the principle of "children first", is essentially aimed at keeping children in the forefront of national priorities and at ensuring that specific programmes for women and children receive priority in the allocation of national resources.

77. The social planning project will involve the establishment of an information and data system for monitoring the situation of mothers and children. The present information system will be revised in order to establish a new method of collection and analysis so as to quantify progress made under various programmes. Particular support will be provided for the establishment of a mother and child monitoring unit within the Ministry of Planning. This will necessitate the training of staff and the computerization of data in order to facilitate rapid and coherent analysis. Backup for the unit will be supplied by university departments, which will help to conduct research into the impact of various social and economic policies on the situation of children.

78. The advocacy project will promote the implementation of plans and policies for CSD. The data and information collected under the planning project will be used to increase the level of knowledge of planners and decision makers so as to improve definition of development policies on behalf of children. UNICEF will provide technical assistance, training, equipment and computerization, produce information and communication materials and assist the evaluation of activities.

Monitoring and evaluation

79. Technical assistance will be provided for the monitoring and evaluation of programme activities, paying particular attention to the Convention on the Rights of the Child, for which a monitoring unit has been established within the Ministry of Youth and Childhood. Monitoring of programme activities will be conducted at the technical department level, and of global objectives at the Monitoring Committee (Ministry of Planning) level.

80. With regard to organizational, management and maintenance activities, UNICEF will assist in maintaining and consolidating achievements in health and education and in developing national capacities to execute programmes concerned with CSD. The Government will report to UNICEF periodically on the level of programme implementation and on objectives attained, as well as on the state of equipment supplied by UNICEF. It will also assume increasing responsibility for programme implementation costs and for developing the capacities needed to ensure programme implementation.

81. UNICEF will continue to work with other United Nations agencies. The joint support of UNICEF and WHO for CDD and MCH immunization programmes will be consolidated and maintained. Similarly, UNICEF and the United Nations Population Fund (UNFPA) will cooperate in the development of the MCH project, in addition to other agencies, donor countries and NGOs. Every effort will be made to ensure cooperation in monitoring the objectives for the 1990s.

III. PALESTINIAN CHILDREN AND WOMEN IN THE SYRIAN ARAB REPUBLIC

U5MR: 45
IMR: 32

Child population (0-5 years): 58,000
Literacy (male/female): 93/75 per cent
Access to health services (total): 95 per cent

One-year-olds fully immunized against:

tuberculosis:	98 per cent
diphtheria/pertussis/tetanus:	94 per cent
measles:	94 per cent
poliomyelitis:	94 per cent

Pregnant women immunized against:

tetanus:	48 per cent

The situation of children and women

82. The Palestinian population living in the Syria Arab Republic is currently about 300,000 and is growing at a rate of 3.3 per cent annually, with more than 90 per cent living in camps around cities, mainly Damascus (77 per cent). About 95 per cent of Palestinians are registered with the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) and are eligible for its services, including health, education, nutrition and environmental sanitation. The General Organization of Palestinian Arab Refugees (GOPAR) is the government agency responsible for overseeing the administrative and civil status needs of Palestinians.

83. Palestinians have been hit hard by the severe economic crisis in the Syrian Arab Republic that is rooted in major decline in external assistance and a dramatic fall in foreign remittances, exacerbated by the situation between Iraq and Kuwait. Since the mid-1980s, there has been a 65 per cent depreciation in local currency, a 45 per cent fall in per capita income and widespread unemployment. This situation has made it increasingly difficult for many Palestinian households to meet their basic needs, as food expenditure accounts for 46 per cent of an already depressed family income. Evidence suggests that malnutrition levels, which declined steadily in the early to mid-1980s, may once again be increasing. UNRWA records indicate a rise in the incidence of malnutrition among children under three years old from 1.3 per cent in 1987 to 14 per cent in 1989.

84. The UNRWA health system provides the vast majority of Palestinians with PHC services. Based on UNRWA records, IMR has declined from 41 per 1,000 in 1984 to 32 per 1,000 live births in 1989. The main causes of IMR are ARI (23 per cent), pre-maturity and congenital malformations (27 per cent) and diarrhoeal diseases (13 per cent). ARI, diarrhoea and accidents are the main causes of infant and child morbidity. Neonatal deaths account for 46 per cent of IMR, owing mainly to tetanus and perinatal conditions. About 80 per cent of children are breast-fed for more than six months.

85. Maternal mortality is estimated at 110 per 100,000 live births, mainly caused by haemorrhage, pre-eclampsia and womb lacerations. Other contributing factors include a high fertility rate (six children per woman of child-bearing age), a short birth spacing in one third of births and the prevalence of iron deficiency among 50 per cent of pregnant women (1984 WHO/UNRWA survey). About 36 per cent of births occur at home, most of which are attended by poorly trained traditional birth attendants (TBAs). Female illiteracy is estimated at 25 per cent.

86. The UNRWA school system provides primary and preparatory education for 80 per cent of Palestinian children. Primary school enrolment is almost universal (100 per cent for boys and 97 per cent for girls), while enrolment in preparatory and secondary schools is 58 and 46 per cent, respectively. Pre-school facilities cater to only 7 per cent of the target group.

87. The social status and responsibilities of Palestinian women differ from women in many other Arab societies owing to the unique nature of life in a refugee community. The politicized nature of the camps, the high value placed on education and the need for women to head households (owing to the absence of adult males for reasons of education, employment, etc.) all serve to promote women's participation in family and community decision-making. However, a 1989 sample survey estimated the share of women in the paid labour force to be only 11 per cent.

88. In addition to the network of UNRWA services and the administrative support of GOPAR, a large number of Palestinian NGOs are active in the camps in areas such as community development, income-generating activities, adult literacy, health and young child care. Unfortunately, coordination among the various groups is generally poor, often causing gaps in service coverage.

89. The Syrian Arab Republic's mass media has been an effective and cooperative ally in efforts to disseminate messages related to children's health and education. Virtually all Palestinian households have access to radio and television, making frequent mass-media campaigns promoting UNICEF priority issues especially effective.

Programme of cooperation, 1984-1990

90. UNICEF cooperation in the period 1984-1990 sought to improve the health conditions of Palestinian children and mothers with the aim of reducing infant, child and maternal mortality and morbidity. Special assistance was also directed to the improvement of water supply and sanitation services and the promotion of early childhood development.

91. In the field of health, UNICEF assistance was channeled through UNRWA and focused on immunization, CDD and safe motherhood. The programme recorded significant achievements in child survival and maternal health. Immunization coverage for children under one year of age reached 94 per cent for DPT3 and OPV3, 98 per cent for BCG and 94 per cent for measles vaccine. About 48 per cent of pregnant women have been immunized with at least two doses of

tetanus toxoid. ORT practices have been integrated with MCH services. A 1986 WHO/UNRWA survey showed that 90 per cent of mothers recognized ORS packets, and 72 per cent used them at home. In the area of safe motherhood, UNICEF supported efforts to upgrade MCH services and sponsored campaigns to promote birth spacing and safe delivery practices. Some 50 TBAs were also trained and provided with midwifery kits. UNICEF has recently sought to make increased use of health facilities of local NGOs to provide services to unregistered refugees and those living in unofficial camps.

92. UNICEF supported a water supply and sewage network, benefiting some 7,000 people in the Qabr Essit camp near Damascus, and provided eight hand-pumps to expand water supply to 60,000 people in eight camps. During the programme cycle, UNICEF sought to shift away gradually from expensive infrastructure projects and towards efforts aimed at mobilizing communities to take action on promoting efficient water utilization, proper sanitation facilities and safe personal hygiene practices.

93. With UNICEF support, 10 kindergartens were established to serve over 1,000 children. Support included educational material, furniture and training of kindergarten teachers. Increased attention was paid to train the teachers on early childhood development methods and to encourage community-based action to ensure that children receive effective stimulation. The project also sought to inform mothers of the importance of early childhood development so that children receive effective stimulation at home, as well as in community facilities.

Recommended programme cooperation, 1991-1994

Estimated annual expenditure

(In thousands of United States dollars)

General resources	1991	1992	1993	1994	Total
Health	80	70	70	70	290
Education	90	100	105	105	400
Advocacy/planning	30	30	25	25	110
Total	200	200	200	200	8 000
Supplementary funding					
Women's development	200	200	200	200	800
Total	200	200	200	200	800
Grand total	400	400	400	400	1 600

94. The new programme of cooperation was prepared in consultation with the Government of the Syrian Arab Republic and UNRWA, Palestinian NGOs and grass-roots organizations. It reflects a common commitment to the priorities and strategies for the 1990s, as well as the experience gained in CSD in the Syrian Arab Republic during recent years.

95. Planning for the 1991-1994 programme cycle began in March 1989, with the preparation of a situation analysis of Palestinian children and women and a strategic framework for future cooperation. The programme of cooperation was developed with an acute awareness of the unique requirements of a refugee population and with the aim to utilize limited financial, human and institutional resources in such a way as to achieve maximum impact on the greatest number of people.

96. The 1991-1994 programme of cooperation will have three main thrusts: (a) child health; (b) women's development; and (c) early childhood development. A special emphasis will be placed on fostering community action and mobilizing the extensive network of NGOs that exists in the Palestinian community.

Health

97. The health programme will focus on sustaining past survival achievements, and while continuing to maintain cooperation with UNRWA and GOPAR, increased involvement of local NGOs will be ensured. The programme will feature two ongoing projects - EPI and CDD - as well as one new project, the control of ARI. The maternal health component will continue to focus on safe motherhood, and activities will include the training of TBAs and the promotion of enhanced antenatal and pre-natal care for women.

98. EPI aims to sustain a coverage level of not less than 95 per cent for all six antigens for children under one year old; to achieve a zero incidence rate for measles by 1994 and contribute to the eradication of polio by the year 2000; and to increase the tetanus toxoid coverage of women aged 15 to 45 years from 48 per cent (1989) to 90 per cent in 1994. Achieving these objectives will involve the continued promotion of established service delivery points run by UNRWA and GOPAR, and the increased promotion of facilities run by the Palestinian Red Crescent Society and other NGOs. Special emphasis will be placed on improving coverage of non-registered Palestinians through NGOs, maintaining cold-chain operations, improving the disease surveillance system and sustaining public awareness of vaccination. UNICEF will gradually phase out its role as supplier of vaccines, syringes and needles, and cold-chain equipment for EPI over the four-year programming cycle, and instead concentrate on supporting efforts in monitoring and evaluation, disease surveillance, advocacy and community mobilization.

99. The CDD project aims to achieve a 30 per cent reduction in IMR and U5MR caused by diarrhoeal dehydration by 1994. An important element of the project will be to build upon past experience to mobilize communities to take action on promoting public health, the hygienic disposal of excreta and other waste,

safe water sources and proper personal hygiene practices. UNICEF will gradually phase out its role of supplier of ORS packets, and instead become more involved in efforts related to the training of health personnel, the production of promotional materials, monitoring and evaluation and community mobilization.

100. The control of ARI project, which is an important new initiative in the 1991-1994 programme of cooperation, aims to achieve a 25 per cent reduction in under-five mortality caused by pneumonia by 1994 and to reduce morbidity associated with ARI by 25 per cent. Service objectives are to: (a) ensure that by 1994, 50 per cent of ARI cases among children under five years old will be treated using standardized WHO methods; (b) use person-to-person contacts and mass media to make 70 per cent of mothers aware of ARI prevention and treatment; and (c) train various health workers in WHO case management techniques so as to be able to treat 70 per cent of moderate and severe ARI cased in health centres. In the early stages of the project, surveys will take place to assess the extent, nature and causes of ARI, as well as the shortcomings of the existing health infrastructure in dealing with the problem. Based on the results of this research, a plan of action will be drawn up for training health personnel, upgrading existing public and NGO health services and enhancing public awareness of the causes, prevention and treatment of ARI. UNICEF participation in the project will consist of the provision of limited supplies and equipment to the NGOs; support for the production and dissemination of promotional material; technical assistance for training, surveys and the establishment of an ongoing monitoring and evaluation system; and community mobilization.

Women's development

101. The major aim of the women's development project is to exploit more fully the large inherent potential of Palestinian women so as to provide them with greater opportunities for personal development and fulfilment and to enable them to participate more fully in the economic life of the community. Project objectives are to achieve a 25 per cent reduction in neonatal and maternal mortality and morbidity; to reduce female illiteracy from 25 to 15 per cent by 1994; and to increase women's share of the paid labour force from 11 to 25 per cent, also by 1994.

102. The service objectives are to increase the coverage of perinatal and post-natal care, including safe delivery by trained personnel, to at least 95 per cent, and to use social mobilization to ensure that all mothers have access to basic information about safe motherhood, nutrition, birth spacing and breast-feeding. Special emphasis will be placed on identifying at-risk mothers at an early stage in order to minimize complications during delivery, extending the roles of TBAs as links between the community and health system, and promoting the concept of referrals through strengthened clinic and TBA-based MCH services. Project activities will include the training of TBAs and public health workers, the establishment of a monitoring and evaluation system, mass media campaigns and other forms of social mobilization and seminars on safe motherhood. UNICEF will provide midwifery kits and other

supplies for TBAs; education and training materials; technical assistance for training for MCH coverage surveys; and technical support for social communication and mobilization. The safe motherhood project will be carried out in close cooperation with local NGOs and will also involve the Ministry of Health, GOPAR and UNRWA.

103. The project will be based on a comprehensive survey of labour market needs, current skill levels among women and occupational preferences of women. Initial activities will include training five women leaders in the administration, finance and supervision of income-generating projects; providing occupational training for 300 to 500 women annually; and setting up a pilot toy production project for 20 women at Qabr Essit camp. The programme will seek to upgrade the proficiency of adult literacy and vocational training teachers, and to strengthen women's literacy classes by incorporating information on early childhood development and basic health into the curriculum. UNICEF will provide technical and financial support and will also attempt to identify and support existing successful income-generating activities for women. UNICEF will seek to foster grass-roots support and interest through extensive advocacy and through identifying and mobilizing local community groups to become involved in developing income-generating projects for women.

Early childhood development

104. This project aims to continue efforts initiated in the previous programme to upgrade the quality of, and increase access to, early childhood stimulation both at home and at community facilities. Given the many traumas and difficulties associated with growing up in a refugee community, developing the basic social and coping skills that are the product of effective early childhood development activities is especially important for Palestinian children. A special effort will be made to link early childhood development with women's development. This will be accomplished by adding early childhood development messages to the curricula of women's literacy courses; involving individual women and women's organizations in the development and the day-to-day operation of early childhood development centres and kindergartens; encouraging women to enrol in courses to become pre-school teachers; and utilizing the toys and teaching materials needed for facilities for young children as an income-generating opportunity for women. The expansion of such facilities will also free more mothers to pursue activities related to their own development. UNICEF support will include identifying and mobilizing the numerous NGOs and community groups involved to form an integrated early childhood development working group; providing technical assistance to this group in formulating policies and standards on the provision and promotion of this activity; training pre-school teachers; assisting efforts to develop prototype toys and teaching aids; and developing and disseminating early childhood development promotional and educational material for mothers.

Cooperation with organizations of the United Nations system

105. As in the past, close cooperation will be maintained with UNRWA, WHO, and NGOs in the development, implementation and review of child survival projects. UNRWA, the World Food Programme (WFP) and UNICEF will continue to cooperate in the field of maternal and child nutrition. Cooperation will be strengthened with UNRWA, WHO, UNFPA and NGOs in areas related to safe motherhood practices, including TBA training.

UNITED
NATIONS

E

Economic and Social Council

Distr.
LIMITED

E/ICEF/1991/P/L.24
28 March 1991

ORIGINAL: ENGLISH/FRENCH

UNITED NATIONS CHILDREN'S FUND
Programme Committee
1991 session

FOR ACTION

RECOMMENDATION FOR SUPPLEMENTARY FUNDING FOR PROGRAMMES IN THE AFRICA REGION WITHOUT RECOMMENDATIONS FOR FUNDING FROM GENERAL RESOURCES

SUMMARY

The present document contains recommendations for supplementary funding in countries in the Africa region for which no recommendations for funding from general resources are requested at the 1991 Executive Board session. The project proposals submitted here are aimed at expanding or complementing ongoing programmes in the countries concerned. The Executive Director recommends that the Executive Board approve supplementary funding in the following amounts for the projects listed below, subject to the availability of specific-purpose contributions.

Country	Amount (United States dollars)	Duration
Benin	2 175 000	1991-1994
Burundi	10 035 000	1991-1993
Côte d'Ivoire	1 020 000	1991-1992
Guinea-Bissau	2 060 000	1991-1993
Niger	7 535 000	1991-1994

Summaries of individual recommendations follow. A table setting out the planned annual phasing of expenditure for each supplementary funding proposal is given at the end of the document.

I. BENIN

U5MR: 150
IMR: 89
GNP per capita: $390

Child population (0-15 years): 2.2 million
Literacy rate (male/female): 37/16 per cent
Access to health services: 18 per cent

One-year-olds fully immunized against:

tuberculosis:	74 per cent
diphtheria/pertussis/tetanus:	42 per cent
measles:	41 per cent
poliomyelitis:	42 per cent

Pregnant women immunized against:

tetanus:	60 per cent

Elimination of dracunculiasis

1. The 1989 UNICEF Executive Board approved an integrated water supply and sanitation programme for the period 1990-1994 as part of the country programme of cooperation. It aimed to eliminate dracunculiasis (Guinea worm disease) from the Zou province, the most endemic region, and extended efforts begun in the previous programme. Eradication operations and surveillance began in the north of Zou province in 1987, and the results were analysed during an evaluation of the impact of the water supply and sanitation programme on the elimination of dracunculiasis from the area undertaken in December 1990. Results will be available by April 1991.

2. The National Conference on Dracunculiasis Elimination in Benin, held in December 1988, established the basis of a national plan for the elimination of the disease. The huge economic losses, increased school absenteeism and infectious complications, including the risk of tetanus, that result from the disease in endemic zones explain clearly the urgency of an eradication plan. It is estimated that Benin loses nearly 700 million CFA francs in agricultural revenue each year because of dracunculiasis. This heavy loss has encouraged the country to introduce the incidence of dracunculiasis as a new major criteria for selecting villages for the provision of water by pumps or wells.

3. Although concentrated in specific geographic zones, dracunculiasis afflicts all six provinces of the country. The purpose of this project is to go to scale nationally with dracunculiasis elimination. The goal is to reduce the number of cases to 50 per cent of the 1988 level in 1992, 10 per cent in 1993, 0 per cent in 1995 and to certify elimination in 1997. Specific objectives are to identify the resources and partners needed to eliminate the disease and to develop, promote and support activities to eliminate it in all endemic areas and villages.

4. The main strategies of the project are: (a) the integration of health education and community mobilization activities with water supply interventions (with or without hand-pumps) in accurately targeted zones; and (b) strengthening central and local capacity in epidemiological surveillance and eradication activities such as training and supervision. The strategy can be summarized as the identification of endemic areas, training villagers to monitor and prevent dracunculiasis, supporting the villagers with technical intervention and ensuring that all cases are detected and effective preventive measures are taken. Priority will be given first to the most endemic areas and villages in order to reduce rapidly the number of cases. Lessons learned during the last country programme in community organization, social mobilization, health education and training for effective community management will be applied in this project. Coordination, extension and eradication activities of epidemiological surveillance will be effected throughout the national territory in 1991.

5. One major strategy in both the water supply and sanitation and the primary health care (PHC) programmes was the creation and training of village committees in management to further community involvement, direction and cost recovery using the Bamako Initiative strategy. Other health and water supply projects had a similar strategy so that many villages in the country have local committees that direct their development.

6. The project will ensure regional cooperation with neighbouring countries. Its advisory role and epidemiological surveillance responsibilities necessitate technical and logistics support. The coordinating office remains an organ for the collection and dissemination of information, as well as for the conception, programming, training and supervision.

7. In each endemic village, a committee will be responsible for the organization of eradication activities. In many villages, there are committees to maintain a pump, to organize health care or to be responsible for social organization or development. Where no committees exist, a health development committee will be set up in consultation with villagers and village leaders. After training, the committee will be responsible for conducting a monthly incidence search, for preventing infected persons from contaminating water points, for promoting drinking water security and for the operation and maintenance of project interventions and water supply.

8. At the village level, surveillance will be set up in all endemic villages in the country. Advocacy and support for health education, water supply and PHC interventions will be targeted especially to the 28 sous-préfectures (sub-prefectures) with more than 200 cases. Broken pumps in all endemic villages with existing boreholes will be repaired or replaced. Village-level operations such as health education, chemical treatment of water and development of drinking water security methods will be targeted first to endemic villages in the 17 subdistricts with more than 400 cases of dracunculiasis, with possible extension to the 11 subdistricts having between 200 and 400 cases. In the Zou department, village-level activities are

already planned within the framework of the UNICEF-assisted water supply and sanitation programme. The proposed project will extend the methods developed and proven in Zou province to the other endemic areas.

9. At the national level, a geographical information system will be refined in collaboration with the UNICEF water supply, sanitation and environmental sanitation programme. It will integrate all topographic, geographic, administrative, epidemiological, hydraulic, existing infrastructure and project location data with a view to planning and coordinating eradication activities. This system will be directed by a coordinating office that will collect information that can assist eradication, such as monitoring the evolution of different activities and measuring their impact on dracunculiasis prevalence. The office will disseminate the results of this work to all partners.

10. In each endemic village identified, a monthly monitoring search will be organized and disseminated through the most appropriate structures. Other vital health information such as births, deaths, nutritional status and vaccination coverage can be collected at the same time. Annual epidemiological surveillance will also be organized. There will be searches in both primary schools and in villages. The searches will last, on the average, one week per district and may be extended over a period of two months, throughout the country, at the end of the dracunculiasis season. It is planned to hold a national seminar every two years to review the situation and reorient the programme to achieve eventual eradication.

11. In 1993, the first national evaluation by active case search will be undertaken to allow redefining and better targeting of eradication operations. A second national evaluation in 1995, including an active case search, will introduce the final phase of the elimination of dracunculiasis project. At this time, an external and independent evaluation team of experts led by the World Health Organization (WHO) will observe progress accomplished and participate in national active case detection.

12. The water department of the Ministry of Equipment and Transportation is responsible for village water supply. Criteria for the selection of borehole sites will include disease incidence, water points, population and the dynamism of the community as shown by the establishment of a committee. According to search results and based on the provision of water to each endemic village having more than 1 per cent incidence and neither a permanent well nor a hand-pump-equipped borehole, 562 additional boreholes are needed for dracunculiasis elimination. Infection sites lacking drinking water supply must be identified for the water department. The concerned project areas will be contacted about the necessity of having these priority boreholes.

13. In the absence of specific medical treatment, the emphasis in PHC will be on anti-tetanus vaccination in health centres, which will also be responsible for treating complications. The cleaning and dressing of wounds, as well as anti-tetanus vaccination, will help to reduce complications.

14. Modules for teaching about the prevention, treatment and implications of dracunculiasis will be developed and included in the training provided to village health workers in endemic areas as part of the UNICEF-assisted PHC programme. This training will focus on promoting water filtration or chemical treatment; preventing infected persons from putting their feet into water points; and the care and bandaging of emerging ulcers to prevent the dispersion of dracunculiasis larvae and secondary infection. Information on other eradication strategies will be disseminated in order to sensitize villagers during training.

15. At the national level, information campaigns will be undertaken through the mass media. A national dracunculiasis elimination day may be organized in all primary schools, and teaching materials will be prepared by the coordinating office.

16. Possible different eradication strategies and tactics and their viability must still be the object of operational research, which will be conducted in the field by non-governmental organizations (NGOs) and, more specifically, by Peace Corps (United States) volunteers. Documentation and monitoring of methods and impact are essential. The use of filters, which can be made at the village level (clay pots, sand and charcoal) and of cloth strainers as an interim measure, will be promoted. It is necessary to ensure their fabrication, demonstration and distribution, preferably by subsidized sale. As boiling or heating consumes much energy, the project will promote more economically appropriate methods, such as solar water cisterns that can raise the water temperature to 60 degrees Centigrade, which is sufficient to kill the cyclops (a crustacean that serves as the host of the Guinea worm).

17. Applied research on methods to ensure the provision of safe drinking water despite the absence of a hand-pump must address their viability, cost and profitability. Among the methods to be developed are: (a) the construction of buried cisterns near water courses that will fill during the rainy season and supply water during the dry season; (b) the promotion and subvention of home cisterns filled during the rainy season to conserve drinking water in the dry season; (c) the installation of a water filtration system on ponds and reservoirs; and (d) the production of communal filters.

18. Selective support activities for operations research, linked to the steady provision of inputs and detailed impact surveillance, will be initiated and continually sustained. In addition to operational research on eradication methods, on-site research on the use of water and the effect of its chemical composition on the cyclops population will be undertaken. Assistance will be available to researchers of the national university and others to study dracunculiasis.

19. In order to ensure correct exploitation of existing water sources, the programme will survey all endemic villages and repair or replace broken or abandoned hand-pumps, as necessary. Local maintenance systems will be put in place with village committees and local repair teams.

20. Among the major monitoring activities are the establishment and utilization of a geographical information system and a management information system to manage the information collected and target interventions. Monthly surveys will be undertaken in all endemic villages until the disease is eradicated. A village child register will be introduced to monitor health status as well as births and deaths. Studies will attempt to find any cases missed by the monthly system. Each year, a study will be undertaken in all primary schools. In 1991 and 1993, house-to-house searches will be organized in all villages.

21. The "triple A" approach (assessment, analysis and action) will be applied to maximize effectiveness at the community level. This approach will be taught to the village committee members as well as to the technicians responsible for the project.

22. There are three types of progress indicators: direct outcome measurements; village-based interventions; and national capacity. Direct outcome measurements will consist of the number of dracunculiasis cases, incidence levels, the number of villages at various incidence levels and the areas reporting no cases. At the village level, the number of active village committees, functional water supplies and ponds treated will be monitored. At the government level, the number of people trained and the programmes and activities directed to the problem areas will be monitored. Yearly internal evaluations before the major transmission season will allow for programme adjustment. An external mid-term evaluation is planned to ensure that the project is properly targeted. UNICEF will provide technical and support staff as necessary to implement components of the project.

23. Current activities in dracunculiasis elimination have developed strong linkages between the water and health sectors, as well as with several external support agencies. This project plans to continue to reinforce this collaboration, particularly with the Peace Corps and WHO. The Japanese International Cooperation Agency and a German volunteer agency are currently implementing a project to supply water to a number of endemic villages.

II. BURUNDI

U5MR: 196
IMR: 116
GNP per capita: $240

Child population (0-15 years): 2.5 million
Literacy rate (male/female): 53/32 per cent
Access to health services: 61 per cent

One-year-olds fully immunized against:

tuberculosis:	99 per cent
diphtheria/pertussis/tetanus:	82 per cent
measles:	73 per cent
poliomyelitis:	82 per cent

Pregnant women immunized against:

tetanus:	80 per cent

Primary health care

24. The UNICEF programme of cooperation for the period 1988 to 1992 was committed to supporting Government efforts, along with those of other major donors (including WHO, the World Bank and the United States Agency for International Development (USAID)), to establish a national PHC programme. This was included in the national five-year development plan (1988-1992) for Burundi and emphasizes social and preventive health care and structures favouring decentralization at the intermediate level (represented by the provincial hospital).

25. The strong political will of the Government to prioritize PHC activities has accelerated the process of decentralization of the health system begun in 1987 through community participation in health delivery services. UNICEF assistance to this PHC effort has focused on the areas of the expanded programme on immunization (EPI), control of diarrhoeal diseases (CDD), malaria control, control of acute respiratory infections (ARI), acquired immune deficiency syndrome (AIDS), maternal and child health (MCH) and nutrition. Achievements have been made especially in EPI, for which coverage of all antigens increased from 55 per cent in 1985 to 80 per cent in 1990.

26. Despite these successes, there are still many constraints to achieving the objective of "health for all" in Burundi. Health centres and hospitals are not functioning as they should, with problems including the lack of integrated services, inadequate services offered in terms of the needs of communities, insufficient stocks of essential drugs and health supplies, and a lack of motivation on the part of most health personnel. For effective implementation of the PHC system, cooperation between the administrative structure and the local health system will have to be increased, while the participation of communities in the management and planning of health activities at the peripheral level could be strengthened.

27. The strengthening of the peripheral health care system within the framework of the Bamako Initiative has been identified frequently as the best strategy to sustain health components that are already performing well (such as EPI) and to ensure that an effective quality of health services is delivered at peripheral and intermediate levels. Preparatory action to implement the Initiative started in Muyinga province in 1990 and focused on the rehabilitation of 14 health centres and one rural hospital serving a population of 340,000.

28. This proposal will extend the PHC component of the current country programme until 1993. Within this period, UNICEF support will be directed towards government efforts at both national and peripheral levels in the following areas: (a) management and coordination of PHC activities through greater community involvement; (b) support to specific PHC components; and (c) containment of the spread of AIDS and sexually transmitted diseases (STDs) among adults and adolescents. A total of 240 health centres and 21 rural hospitals in the country will be the focus of action during the programme period, with the goal of reaching all 16 provinces by the end of 1993.

Management and coordination of primary health care activities

29. Activities in this area will include further development of a technical unit in the Ministry of Health to manage and coordinate all PHC activities using the Bamako Initiative strategy. This will be done through the reinforcement of human resources, the provision of necessary training and the development of the capacity of central health personnel in relevant fields such as health economics. Five departments will be strengthened at this level in order to implement the Bamako Initiative: (a) the inspectorate general and health planning office; (b) the department of training and personnel management; (c) the department of hygiene and prevention; (d) the unit of epidemiology and statistics; and (e) the department of budget and drugs supply. Attention will be given to health service delivery; improvement in the quality of services offered, including the constant availability of essential drugs; better coordination between health centres and the community; increased community participation; and a stronger health financing system at the peripheral level. The health financing system will be based on the medical insurance card (carte d'assurance médicale), which is purchased annually and provides access to basic services in health structures, as well as on direct payment for services. UNICEF will also support the strengthening of the national health information system, the development of a PHC monitoring system and the intensification of social mobilization and the information, education and communication (IEC) system at central and peripheral levels.

30. The establishment of a reliable referral system between the different levels of the health system will receive relevant support, as this is a key element in the consolidation of the PHC programme. Accordingly, appropriate protocols will be designed to identify those cases to be referred, the wider use of partogrammes will be introduced and a communication system will be established between health centres and rural hospitals.

Support to specific primary health care components

31. Within this system, UNICEF will support specific priority components of PHC, such as EPI, CDD, malaria control, AIDS control, control of ARI and safe motherhood, with the aim of strengthening integrated action at the health centre level. This is important for the institutionalization of a national PHC system in Burundi. The standardization of the national information system, which will provide the Ministry of Health with data on PHC activities and their progress, will play a major role in this integration process.

32. EPI will focus on sustaining the universal childhood immunization coverage rate at 80 per cent for children under 11 months of age and women of child-bearing age, in addition to developing strategies for the eradication of polio and tetanus. In order to achieve those goals, close attention will be given to the differentiation of activities relative to each health zone; the determination of catchment areas and target populations; the identification and analysis of the drop-out rate and development of a system to reduce the rate; and the development of specific activities in the areas with the lowest coverage rates. An alert epidemic/outbreak response system will also be developed and the supply and condition of all vaccines and cold-chain equipment will be closely monitored.

33. Emphasis in CDD/oral rehydration therapy (ORT) will be on the establishment of ORT treatment rooms at all health centres and rural hospitals. Attention will also be given to the development of home-based ORT treatment. Water supply and sanitation activities will play an important role, with plans envisioned to integrate sanitation education into primary school health education programmes.

34. Malaria control activities will aim to provide proper diagnosis and treatment of the disease, including resistant cases, in health centres throughout the country by providing anti-malarial drugs and laboratory equipment and by training laboratory technicians and other health personnel in case management.

35. ARI activities will centre on the development of national standard therapeutic protocols and diagnostic capacities of personnel. Drug needs must be identified, amounts estimated and provision made for their supply. In order to work towards ARI prevention, mothers' capacity to recognize ARI will be strengthened.

36. The analysis of nutrition data with other epidemiological data will be an important requirement for the identification of areas and populations at highest risk, and for the development of plans of action. Activities are also under way to organize a national plan of action for the prevention of both goitre and vitamin A deficiencies.

37. Safe motherhood activities will seek to improve early antenatal care at all health structures in order to ensure that 95 per cent of pregnant women visit them at least once during pregnancy; to inform about and advocate birth spacing; and to ensure safe delivery conditions.

38. The main aim of action for AIDS and STDs is to contain their spread among adolescents and adults, especially girls and women. Most activities will centre on further development of protocols, strategies and diagnostic capacities to identify and slow the spread of AIDS and STDs. In addition, family planning activities and plans for condom distribution will be better coordinated and relevant counselling will be improved. Educational outreach efforts will involve primary and secondary school children, while specific approaches will be developed for those considered to be at high risk, including children not enrolled in schools. The growing problem of AIDS orphans will be more closely studied and relevant strategies identified.

III. COTE D'IVOIRE

U5MR: 142
IMR: 95
GNP per capita: $740

Child population (0-15 years): 5.9 million
Literacy rate (male/female): 63/34 per cent
Access to health services: 30 per cent

One-year-olds fully immunized against:

tuberculosis:	47 per cent
diphtheria/pertussis/tetanus:	42 per cent
measles:	41 per cent
poliomyelitis:	42 per cent

Pregnant women immunized against:

tetanus:	34 per cent

Primary health care and the expanded programme on immunization

39. The health situation in Côte d'Ivoire has been aggravated by the economic crisis and the effects of structural adjustment measures. The Government was forced to reduce its health services budget by 3 per cent and the amount earmarked for PHC by approximately 30 per cent.

40. The situation of children and women in Côte d'Ivoire remains disturbing. Health services are poor and there has been a chronic shortage of essential drugs and supplies in health units since 1989. The under-five mortality rate (U5MR) is 139 per 1,000 live births. Among children, diarrhoea is the primary cause of hospitalization. Acute dehydration ranks third among the causes of infant mortality, while malnutrition ranks fifth. The number of MCH centres is very limited, with only 70 centres for nearly 2 million children under five years of age. EPI target diseases are still rampant, although their overall incidence is lower. The maternal mortality rate (MMR) is estimated at 200 per 100,000 live births in rural areas and 30 per 100,000 live births in urban areas, although 60 per cent of the causes of maternal mortality could be prevented by adequate prenatal care.

41. Outside the towns, the PHC operational structure consists of 26 rural health sectors. Coverage for the various activities (treatment for malaria, diarrhoea and respiratory infections) continues to be low, however, and the present health system is incapable of meeting ever increasing needs. In addition, PHC activities are still carried out as part of vertical programmes, without reciprocal support.

42. The lack of essential drug affects the quality of care for diarrhoeal diseases, ARI, malnutrition and malaria. Several sectors have some experience with village dispensaries, but most are hampered by the lack of follow-up and supervision and the inability to obtain drugs at affordable prices.

43. Many women still die in childbirth; since 1986, MMR has risen progressively. In 1986, 586 maternal deaths per 5,000 deliveries were recorded at the Cocody University Hospital in Abidjan, the capital, and 907 in 1989. Preliminary reports for 1990 indicate more than 1,000 maternal deaths. This situation is more acute in rural areas, where nearly 70 per cent of deliveries take place at home. The reasons given for not using public health facilities include the lack of drugs and the distance involved.

44. Because of this situation, the Government recognizes the need to introduce PHC more rapidly. Steps have already been taken to reorganize the Ministry of Public Health so that it will be more responsive to the PHC approach and to implement a policy to supply essential drugs based on cost-recovery.

45. In 1990, a special effort was made to revitalize EPI, which reached 42 per cent in 1989 and reinforced both the operational capacity of health infrastructures and the development of human resources. Some 316 centres for developing the advanced strategy became operational, so that a total of 484 health centres and clinics are now carrying out regular vaccination activities. In 1991 and 1992, 150 new centres will be equipped.

46. According to an evaluation conducted in the south-east region in May 1991 among children aged 12 to 23 months, 93 per cent had been vaccinated against tuberculosis; 77 per cent with three doses each of diphtheria/pertussis/tetanus and poliomyelitis vaccines; 70 per cent against measles; and 50 per cent against yellow fever. Despite those efforts, geographical accessibility remains difficult and vaccination rates are poor in several rural health sectors. Because of "pockets" of epidemics in certain areas, the achievements of EPI must be rapidly consolidated and mechanisms of adapted epidemiological supervision must be instituted.

47. Through the proposed programme, the Government and UNICEF seek to integrate EPI with other PHC components in four rural health sectors, while continuing to accelerate EPI throughout the entire country. UNICEF will assist the Government in its efforts to develop a coherent, integrated and coordinated PHC policy based on the principle of the Bamako Initiative, which should result in a rapid improvement in MCH while sustaining the achievements of EPI. Because the 26 rural health sectors are actively involved in EPI, progress made in this area can rapidly be applied to the integration of the preventive and curative PHC activities.

48. The objectives of the PHC/EPI programme for the period 1991-1992 will be (a) to strengthen EPI activities; (b) to upgrade the quality of MCH care; (c) to support and strengthen current community self-financing efforts by supplying essential drugs; (d) to strengthen social mobilization and IEC activities in these areas; and (e) to provide technical support to the programme.

49. The programme will have two elements: (a) strengthening decentralized national services; and (b) promoting community participation.

50. The programme aims (a) to evaluate vaccination coverage by health sector in January 1991; (b) to rehabilitate the central warehouse and equip 150 new centres; (c) to strengthen the capacity of 20 MCH centres in pilot areas; (d) to enhance accessibility to and quality of services of 150 health centres; (e) to train 60 public health officers and 300 paramedical workers in PHC management; (f) to train 200 traditional birth attendants and 200 community health workers; (g) to supply 170 health units and 200 village dispensaries with essential drugs; (h) to formulate a three-tiered supervision and monitoring programme consisting of village health committees, sub-prefectures and rural health sectors; (i) to formulate an EPI disease watch programme; and (j) to develop social mobilization structures through personnel training, follow-up and the preparation of educational materials.

51. The social mobilization programme established to support EPI will continue concurrently with the technical and material components. It began with the training of technical and social staff in the 26 rural health sectors and the establishment of local committees, closely monitored by an interministerial team of 10 instructors. The programme will include the other aspects of PHC in order to generate awareness and enhance the community's commitment to promoting health on its own initiative.

52. Management and follow-up tools will be deployed for gathering information in the various fields. There will be regular follow-up, supplemented by a study of the dispensaries in 10 rural health sectors. Two national-level evaluations of vaccination coverage will be conducted in order to measure progress at the beginning and end of the programme period.

53. While the programme will be implemented by the technical services of the Ministry of Health, a partnership will be developed with the other participants in the health system, including WHO, NGOs and bilateral agencies.

IV. GUINEA-BISSAU

U5MR: 250
IMR: 148
GNP per capita: $190

Child population (0-15 years): 404,000
Literacy rate (male/female): 46/17 per cent
Access to health services: N.A.

One-year-olds fully immunized against:

tuberculosis:	90 per cent
diphtheria/pertussis/tetanus:	58 per cent
measles:	44 per cent
poliomyelitis:	58 per cent

Pregnant women immunized against:

tetanus:	29 per cent

Rural water supply and sanitation programme and well-diggers' training project

54. Two separate projects make up the water supply and sanitation programme in the current programme of cooperation (1989-1993). The rural water supply project and well-diggers' training project were developed during the first two phases of implementation (1979-1986) in the western part of the northern region, between the villages of Varela and Campada where 120 wells were constructed to benefit approximately 12,000 people. Nineteen teams of well-diggers, including a team of drillers, had been trained in construction techniques for improved wells, village mobilization and sanitary education.

55. Following the conclusion of the first two phases of implementation, the third phase began in 1987, with the aim of constructing 100 wells in the region between Campada (25 in the São Domingos sector) and Ingore (75 in the Bigene sector) to serve a further 10,000 beneficiaries. These sectors of the region of Cacheu, where rainfall is low and very sporadic, were chosen because they were most deprived of drinkable water sources.

56. During the third phase, the training of new well-diggers had to be interrupted due to the Government's financial constraints in paying technicians' salaries. An evaluation mission in 1988, which included the participation of the Danish International Development Agency (DANIDA), considered the project's execution and positive impact and proposed several recommendations, including an extension of activities.

57. The objectives of this new fourth phase (1991-1993) will include (a) ensuring community support for operating and maintaining the 220 wells constructed; (b) continuing well-diggers' training and refresher courses and transforming and upgrading the São Domingos school into a national training centre with improved curricula; (c) building 36 new wells per year in the Bigene sector to benefit 3,600 persons, thus meeting the national goal of 400 wells for the zone; and (d) progressively introducing manual pumps and of latrine construction into the project.

58. UNICEF will ensure the provision of materials necessary for the maintenance of wells already constructed and construction materials for new wells and improved latrines, and will also absorb some logistics overheads. Prior to their more widespread introduction, and in collaboration with the project for maintenance and animation in the rural water sector, 25 hand-pumps conforming to national standards will also be installed on constructed wells in communities that are willing to participate in maintaining and repairing the pumps. The introduction of a maintenance system with trained local mechanics, who are provided with tool boxes and bicycles, and the creation of a maintenance centre in Sao Domingos are foreseen.

59. The Ministry of Natural Resources is eager to develop a national standardized training programme and animation activities covering maintenance of water sources, hygiene and sanitation so as to reach a common approach and methodology and to avoid duplication of efforts. According to present forecasts, two teams per year totalling 12 people will need to be trained in seven-month courses. The overall government strategy is to drill 2,000 boreholes and construct 400 improved wells. Seven well-digging teams (28 persons) will be required in the near future to serve the regions of Gabu, Bafata, Biombo and Boloma/Bijagos. A survey will be undertaken to better assess the national needs of qualified well-diggers. UNICEF will help to expand and equip the well-diggers' school to include more classrooms and a canteen and dormitory.

60. A technically well-constructed water source does not automatically guarantee better health conditions in a village. Prior to improving well construction and sanitation activities, communities will be sensitized to the project's goals of participatory development and self-financing. Before starting a sanitation programme, it will be essential to plan and undertake knowledge, attitude and practice (KAP) studies. Great importance is attached to IEC activities. The project will benefit from the experience in the Gabu and Bafata regions in the eastern province in linking sanitary education about water with hygiene and sanitation issues. The introduction on a pilot project basis of low-cost improved, ventilated latrines in primary schools and health centres is proposed.

61. UNICEF will assure technical assistance to the project through the recruitment of (a) a project officer to serve as advisor to the national project director; (b) a United Nations volunteer as technician/mechanic who will cover training, mechanic maintenance and logistics; and (c) an expert hydrologist. In addition, a DANIDA-sponsored anthropologist will facilitate project monitoring, studies and operational research.

Training rural women for self-employment in improved food processing, storage and marketing

62. The project will be closely linked with the other water supply and sanitation project in the Gabu and Bafata regions, as well as with the social communications team. Since its inception, the World Food Programme (WFP) has ensured food support to the well-digger trainees. The Governments of Denmark and the Netherlands also provide vital support.

63. A technical interministerial committee will assure follow-up by consulting monthly reports on the development of activities, including the control of delivery and utilization of materials and equipment. A quarterly revision of progress will be made and the project will be evaluated every November. A mid-term review of the entire programme of cooperation is scheduled in 1991, with a final project evaluation in 1993.

64. While there is no immediate threat of food insecurity owing to the lack of agricultural production in Guinea-Bissau, there is evidence of micronutrient deficiency in certain groups, while widespread parasitic infestation, endemic malaria and diarrhoeal diseases among children reduce food absorption and intake. Food prices have also risen dramatically under the structural adjustment programme, and as survival strategies of urban and rural households are threatened, a decline in food demand is noticed, especially among poor and vulnerable groups. Therefore, the training of rural women for self-employment in improved food processing, storage and marketing is necessary.

65. Fruit and crop processing, storage and marketing are poorly developed in Guinea-Bissau. Women, traditionally in charge of these activities, are already overworked and have little time for learning new skills. Consumers are unaware of the potential nutritional and economic value of already available foods and are unfamiliar with new processed products. Together, these factors deprive both producers and consumers of a wider range of goods and restrict incomes for poor women. In the process, valuable food resources are wasted each year.

66. Safeguarding child and maternal welfare involves a range of interrelated measures. Economic measures are needed to avoid serious deprivation among vulnerable groups experiencing declining access to productive resources and employment. Ways need to be found to diversify diets, to teach overworked women new processing and management skills and to generate effective demand among potential consumers for a wider range of low-cost food.

67. This is a broad-based social communications programme that is designed to complement existing and planned fruit and vegetable processing initiatives implemented through the Ministry of Rural Development and Agriculture. Although UNICEF has had no involvement with that Ministry to date, the programme will provide the educational and mobilization inputs to complement the technical support being offered through the processing and storage upgrading project of the Food and Agriculture Organization of the United Nations (FAO). It will teach new or improved processing and storage skills and marketing, basic stock and accounting techniques. The UNICEF-supported component will also develop marketing material aimed at consumers.

68. The objectives of this collaborative FAO/UNICEF programme are (a) to encourage the efficient utilization of existing fruit and other potentially viable crops; (b) to raise incomes of women producers by improving returns to both labour and time; (c) to improve household food security among poorer sections of the community; and (d) to improve nutritional status and reduce

micronutrient deficiencies. Improved child welfare and the receptiveness of women to education and health programmes are indirect benefits anticipated by offering improved working practices and conditions to mothers.

69. The programme, operating in the regions of Bafata, Biombo, Quebo, Quinara, Tombali and the Bissau Green Belt, emphasizes the participation of local groups and intended beneficiaries, and each community will be encouraged to adapt the skills and techniques being offered to its own specific material needs and cultural context. The structure and membership of groups will be decided by women themselves, and care will be taken to see that new activities do not inadvertently raise overall workloads by overlooking linkages with other activities for which women remain responsible.

70. UNICEF inputs comprise four main components: (a) research and pre-implementation preparation; (b) the transfer of new processing and management skills; (c) education and mobilization; and (d) material support at the local level.

71. Using KAP surveys, the pre-implementation component will investigate existing processing, consumption and marketing activities for the groups of food crops covered by the project. The prevailing sexual division of labour in each project area and the likely impact on different types of new or improved crop processing will be assessed. Dietary practices will be reviewed. This research provides an excellent opportunity for information collection to update the situation analysis on women, and will, in turn, be fed into materials development and mobilization activities over the three-year duration of the programme.

72. The transfer of new processing and management skills will initially focus on improved cassava, based on experiences in Nigeria, but UNICEF technical assistance will also support teaching new techniques for fruit processing and storage and honey production. Basic courses in stock management and marketing will also be given, including storage and bookkeeping. The project will offer specific assistance to groups of women wishing to establish cooperative ventures.

73. Education and mobilization materials will be prepared both to convince producers of the potential market and to show consumers that the products targeted by the programme are nutritionally valuable and comparable to existing foods in both preparation time and cost benefit. Experimental television in Guinea-Bissau will develop, produce and broadcast appropriate supporting programmes to the channel's network of "community television". The UNICEF-supported social communication project is well placed to support the preparation of programmes and will assist with materials, transport costs and specific technical support for mobilization materials. Three technicians will be selected to participate in short production courses in Brazil or Portugal.

74. Groups of women may acquire start-up materials and credit from the UNICEF-assisted project, but these will be provided on a loan repayment basis. Successful examples of such schemes already exist in the south of Guinea-Bissau and will be duplicated. Training for new skills will be provided to local community members and, where necessary, assistance in manufacturing equipment will be offered.

75. A group of eight persons will be selected to work as local-level coordinators and trainers, providing technical assistance for the first two years of the programme. Existing rural development structures will be used to manage and supervise the programme. Over the three years, three reports by specialists will investigate the progress of acceptance by both producer and consumer groups of the new processes and products. Progress reports will be prepared at the end of the second and third years and a final programme evaluation report will be prepared by the Ministry of Rural Development and Agriculture.

V. NIGER

U5MR: 225
IMR: 132
GNP per capita: $300

Child population (0-15 years): 3.7 million
Literacy rate (male/female): 32/11 per cent
Access to health services: 41 per cent

One-year-olds fully immunized against:

tuberculosis:	25 per cent
diphtheria/pertussis/tetanus:	12 per cent
measles:	12 per cent
poliomyelitis:	11 per cent

Pregnant women immunized against:

tetanus:	18 per cent

Integrated primary health care

76. The proposed PHC programme falls within the framework of the programme of cooperation for the period 1990-1994 (E/ICEF/1989/P/L.7). Its objective is to accelerate the development of PHC in the Niger as part of the Bamako Initiative, the practical arrangements for which were still being negotiated when the Executive Board adopted the programme of cooperation. The goal of the PHC programme is to upgrade the assets available for reaching the target set in the current programme of cooperation for reducing the high infant mortality rates (IMRs), U5MRs and MMRs by 25 per cent. In 1988, they were estimated at 134 per 1,000 live births, 228 per 1,000 live births and 700 per 100,000 live births, respectively.

77. The current programme of cooperation was begun in the midst of an economic crisis that had sharply diminished Government investment capacity. The gross domestic product dropped by nearly 32 per cent between 1981 and 1987 because of the steady devaluation of export prices, particularly of uranium, the country's chief source of income. In addition, a persistent drought, which in 1984-1985 had been responsible for one of the most disastrous harvests in the country's recent history and had resulted in a deficit of 478,000 tons of millet and sorghum, is still adversely affecting farming. The Government has also incurred a heavy debt, and debt servicing absorbs 60 per cent of tax revenues.

78. The integrated PHC component seeks to maximize the cost-effectiveness of available resources. The major obstacle to instituting PHC in the Niger is the lack of continuity between the activities of village health workers (VHWs) (who serve 45 per cent of villages, where they provide minimum services) and the national-level health programmes, which have developed vertically. UNICEF will support Government efforts to increase and sustain vaccination coverage rates and promote the use of health services in order to help reduce IMR and MMR by offering quality preventive and curative care.

79. The PHC component for the period 1991-1995 will be based on the following strategies:

(a) Revitalization and extension of health centres, whose workers will become focal points for integrated and essential preventive and curative health care. These workers will support VHWs in their activities, particularly by monitoring and supplying essential drugs;

(b) Effective popular participation in the planning, management and evaluation of activities, and in the management of health centre resources. This management will continue at the village level and extend to the health centre level;

(c) Grass-roots action to mobilize, co-finance and control resources for the operation of health centres, to provide the necessary resources, including essential drugs, and to streamline their use and management.

80. Thus, the health system outside the towns will be able to ensure, in an integrated manner, effective coverage of the population through specific activities in the following priority areas: (a) MCH and family planning; (b) universal immunization; (c) malaria control; (d) CDD and ORT; (e) control of ARI; (f) education and nutrition rehabilitation; and (g) education for health and improved sanitation, particularly with a view to containing infectious and parasitic diseases such as AIDS and dracunculiasis.

81. The necessary bases will then be established for reaching the following targets:

(a) Between 1991 and 1992, increasing access to MCH services by 21 to 50 per cent for children under five years old and by 32 to 50 per cent for women of child-bearing age;

(b) Ensuring universal immunization by 1995 by vaccinating 80 per cent of children aged under 11 months for all antigens, and child-bearing women against tetanus;

(c) By 1995, reducing mortality caused by diarrhoea by 25 per cent among children under five years of age; attaining an ORT use rate of 60 per cent for children under five years old suffering from diarrhoea; and treating 90 per cent of children in case of cholera epidemics;

(d) Treating annually at least 50 per cent of malaria cases among children under five years of age, using the established treatment procedure;

(e) Treating annually at least 10 per cent of ARI cases, using the standardized treatment procedure;

(f) In the area of education and nutritional rehabilitation, reducing the current rate (20 per cent) of chronic malnutrition among children under 5 years of age to less than 10 per cent, convincing 50 per cent of mothers who frequently use health centres to feed their children properly in order to prevent and treat malnutrition, reaching a recovery rate of 25 to 50 per cent among children under five years old suffering from malnutrition and developing preventive activities for malnutrition control by consolidating the experiences of the UNICEF/WHO joint nutrition support programme and systematizing regular follow-up and growth promotion among 80 per cent of children living within a 15-kilometre radius of the health units;

(g) Promoting the use of essential drugs by upgrading the training of 100 staff members in management and 1,000 pharmacists in the more rational use of drugs; contributing to the development of 100 fund management committees so that they can play a role in the integrated development programme and contributing to the development of a system of grass-roots participation by establishing a local solidarity fund through the various community development activities; promoting education for health in order to upgrade the habits of at least 25 per cent of mothers in the departments concerned in nutrition, hygiene and infectious and parasitic diseases, including AIDS and dracunculiasis and eradicate dracunculiasis by 1995; in the area of social communication and mobilization, reactivating six radio-club centres by training 120 operators.

82. The main activities of the programme will be as follows:

(a) Maintaining the achievements of EPI while integrating other services;

(b) Analysing the current functioning of the health system at district, health centre and village levels (based on existing studies) and micro-planning of activities at the district levels in order to guarantee efficiency and sustainability in accordance with the principles of the Bamako Initiative;

(c) Training communities and health workers in the management and organization of health activities in order to ensure the acceptance of responsibility at the local level;

(d) Providing areas outside the towns with basic supplies of essential drugs, equipment and management and information tools for the health system.

83. The following specific activities will also be conducted in priority fields:

(a) EPI will give particular attention to (i) increasing the number of permanent vaccination centres from their present level of 166 to 320 operational centres by 1995, so that 80 per cent of vaccination activities should be carried out as part of the advanced, permanent strategy and the remainder as part of the mobile strategy; (ii) training 1,000 health workers in vaccination methods by including an EPI module in the health studies curriculum; and (iii) the recovery of health and other community development costs (such as water-point maintenance costs) from the sale of health cards;

(b) MHC/family planning services will be reinforced by (i) providing 250 health units and 2,500 village health teams with technical equipment and teaching materials for upgrading services; (ii) instituting a system for growth monitoring and promotion for children under five years old at 250 health units by 2,500 village health teams; and (iii) introducing new nutrition and growth monitoring methods and methods for children under five years old and nutritional surveillance of pregnant and nursing mothers in 250 health centres by 2,500 village health teams;

(c) Malaria control will emphasize educational sessions to be organized at least once a year by health centre workers in the villages serviced. The sessions will focus on topics related to malaria among children under five years old and pregnant women and means of malaria control;

(d) ARI activities will include (i) convincing the health authorities to establish a standard ARI treatment procedure; (ii) organizing, at least once a year, in villages within a 15-kilometre radius of the health centres, an educational session on ARI among children and the means of controlling related mortality; and (iii) annually treating at least 10 per cent of ARI among children using a standardized procedure;

(e) In the area of education for health, the National Department of Education for Health will be equipped to help strengthen an ongoing IEC health mechanism; one regional and five subregional units will be developed for the purpose of educational and social mobilization activities for health; and mechanisms for PHC self-management by village communities will be instituted in 2,500 villages in the departments of Agadez, Maradi, Tahoua, Tillabery and Zinder;

(f) AIDS control will focus on (i) IEC sessions on AIDS at 90 secondary schools; (ii) producing and broadcasting at least five radio and television spots and one information and public awareness film on AIDS in 1991; and (iii) training 10 IEC instructors by 1992;

(g) Staff training activities will include (i) retraining 1,000 health workers and 2,500 village health teams by supplementing their technical knowledge and training them in administration; and (ii) contributing to staff training through the annual allocation, over five years, of 35 nursing and midwife fellowships, two fellowships for a paediatrician and obstetrician/gynecologist in training and two dieticians, beginning in 1993;

(h) The main social mobilization/communication activities will consist of (i) training 2,500 leaders of samarias (a traditional Niger youth association for solidarity and mutual assistance in the villages) in health and nutrition education in the departments of Agadez, Maradi, Tahoua, Tillabery and Zinder; and (ii) training 300 leaders, including 150 women and 50 staff members, at department and district levels, in methods of popular social mobilization.

Estimated annual expenditure

(In thousands of United States dollars)

Country/programme	1991	1992	1993	1994	Total
Benin					
Dracunculiasis elimination	375	625	590	585	2 175
Burundi					
PHC through the Bamako Initiative	3 745	3 280	3 010	-	10 035
Côte d'Ivoire					
PHC/EPI	680	340	-	-	1 020
Guinea-Bissau					
Rural water and well-diggers training	690	645	369	-	1 704
Training rural women for self-employment	150	130	76	-	356
Subtotal	840	775	445	-	2 060
Niger					
Integrated PHC	2 269	1 793	1 738	1 735	7 535
Total	7 909	6 813	5 783	2 320	22 825